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Governor

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Director

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DRAFT MCAC MEETING MINUTES

Date and Time of Meeting:	April 19, 2016 at 9:00AM
Place of meeting:	Nevada State Legislature Building 401 S. Carson Street, Room 3138 Carson City, Nevada 89701
Place of Video Conference:	Grant Sawyer Office Building 555 E. Washington Avenue, Suite 4406 Las Vegas, Nevada 89101
Teleconference:	(877) 402-9753
Access Code:	7316372

Attendees

Board Members (Present)
Rota Rosaschi, Chairperson
Peggy Epidendio, Board Member
Leon Ravin, Board Member
Ryan Murphy, Board Member

Board Members (Absent)
David Fluitt, Board Member
David Fiore, Board Member
Michael Ball, Board Member

Carson City
Darrell Faircloth, Senior DAG
Cheri Glockner, HCGP
Marti Cote, DHCFP
Paula Barcley, HCC
Sandie Ruybalid, DHCFP
Shannon Sprout, DHCFP
Elizabeth Aiello, DHCFP
Tammy Moffitt, DHCFP
Gladys Cook, DHCFP
Tom Sargent, DHCFP
Tracy Palmer, DHCFP
Thomas McCrorey, HCGP
Jacob Douglas, DHCFP
Andrew Rico, DHCFP
Laura Palotas, DHCFP
Lynne Foster, DHCFP
Gloria Macdonald, DHCFP
Tammy Ritter, DHCFP
Rachel Marchetti, DHCFP
John Kucera, DHCFP

Blayne Osborn, NRHP
Kathy Stoner, DHCFP
Bette DesRuisseaux, DHCFP
Kim Gahagan, Health Plan of Nevada
Renee Necas, DHCFP
Erin Snell, HCGP

Las Vegas
Michelle Guerre, Health Plan of Nevada
James Hartsell, Public
Mary Hartsell, Public

I. Call to Order

Chairwoman Rosaschi called the meeting to order at 9:04 AM.

II. Roll Call

Chairwoman Rosaschi asked for roll call. A quorum was established. Chairwoman Rosaschi stated that this was properly posted and it does meet the open meeting laws.

III. Public Comment on Any Matter on the Agenda

Ms. Hartsell, a licensed marriage and family therapist, spoke of being concerned about a rumor that Fee for Service (FFS) is going to be taken away from therapists.

Chairwoman Rosaschi replied that this topic is not on the agenda and referred her to Ms. Aiello, Deputy Administrator, to speak with after the meeting.

IV. For Possible Action: Review and Approve Meeting Minutes from January 19, 2016 (See Attachments)

Dr. Ravin abstained from approving the minutes as he was not in attendance. His abstention was accepted. The January 19, 2016 minutes were approved as written.

V. Administrator's Report, Present State Plan Amendments (SPA) and Medicaid Services Manual (MSM) Updates by Elizabeth Aiello

Ms. Aiello reported on the SPAs submitted to the Centers for Medicare and Medicaid Services (CMS). Ms. Aiello also covered the MSM updates. See attached report.

Ms. Aiello informed the committee that Nevada Medicaid has sat on the Governor's Interagency Council on Homelessness. She stated that since Medicaid's expansion population includes a large amount of homeless, the division can't deliver home health services if there's no home to go to. Prevention or follow up health care is also a challenge. It was suggested by the Governors Interagency Council that the division prepare a budget concept for Medicaid Resident Assessment Protocols (RAP) services for the homeless.

Ms. Aiello told the committee that CMS launched an Innovation Accelerator Program. This program would help states to get RAP services to homeless individuals in Medicaid. Nevada was one of eight states that was awarded one on one technical assistance. Nevada was also one of two states that were asked to go to Washington D.C. to report on homelessness because of the

number of collaborators, including the Governor's Office support and the Interagency Counsel on Homelessness.

Chairperson Rosaschi congratulated Ms. Aiello on her visit back east.

Chairperson Rosaschi inquired about the projected outcome of the homelessness project.

Ms. Aiello replied that the goal would be to develop some RAP services that Medicaid can fund. Some of those services are housing transitions and teaching recipient tenant responsibilities, and financial planning. Sometimes this group of people crossover with the Medicaid Mental Health/Behavioral Health services. It is going through the Governor's Interagency Council and the division doesn't know yet if it will be funded.

Chairperson Rosaschi commented that it is exciting because Nevada is usually on the bottom of lists and we are actually on the top of a good list this time.

Ms. Epidendio asked Ms. Aiello if we have any idea when the federal funds might be approved.

Ms. Aiello replied that there will be no federal funds unless the program is approved as part of the state's Medicaid program. It will have to become part of a budget concept paper, which would have to be authorized by the Governor's Interagency Council of Homelessness. The division would be awarded the technical assistance grant, funded by the federal government.

VI. Update and Discussion on the Health Care Guidance Program (See Attached Presentation)

By Cheri Glockner, Executive Director, Health Care Guidance Program, and Dr. Thomas McCrorey, Medical Director, Health Care Guidance Program

Dr. Ravin questioned if they make specific efforts to track two or more medications prescribed for the same reason.

Dr. McCrorey answered that in some categories they do track them if they are in the same class. He stated that the alerts are for every possible medication error. They are more oriented towards the behavioral health medications.

Dr. Ravin asked if they have considered tracking data about prescribed medications outside of Food and Drug Administration (FDA) guidelines.

Dr. McCrorey replied that some of the alerts are based on that. The Medical Director and the Psychiatric Director took the ones that they felt were most dangerous and outside of the FDA guidelines and created alerts for those.

Mr. Faircloth wanted clarification on how the Health Care Guidance Program (HCGP) is different from Optum, Medicaid's pharmacy vendor.

Dr. McCrorey replied that HCGP focuses more specifically on dangerous prescription practices as opposed to whether or not they are following the state Medicaid guidelines. HCGP picks up

when a person is getting multiple prescriptions from multiple providers and unknowingly has medications in the same class that may work against each other. That is when it becomes a safety issue.

Mr. Faircloth requested further clarification that HCGP is focused more on the target population than the broader mandate that Optum is working under.

Dr. McCrorey agreed to that statement. He stated that their patients are more likely to be the chronically ill and are more likely to be on multiple medications than on any other program.

Chairperson Rosaschi thanked Dr. McCrorey for giving a good report.

VII. DHCFP Reports

- **For Possible Action: Discussion, Review and Possible Approval of Managed Care Marketing Materials (See attached documents)**

  By Laura Palotas, Business Process Analyst I/Managed Care Enrollment Specialist

  Ms. Palotas presented revisions for Health Plan of Nevada's (HPN) Marketing Materials.

  Ms. Epidendio stated that she found a lot of inconsistencies in the documents and would like to talk to her after the meeting about them.

  Ms. Palotas informed Ms. Epidendio that representatives from HPN are available for consultation because ultimately any suggestions would have to go to them.

  Chairperson Rosaschi wanted to thank HPN for the revisions because she had some concerns about some of the examples the first time they submitted the documents.

  Chairperson Rosaschi took a motion of approval in concept of the marketing materials. Motion granted.

- **Presentation on Nevada Quality Strategy Public Workshop December 2015 (see attached presentation)**

  By Tracy Palmer, Social Services Chief II Managed Care & Quality

  No comments or questions.

- **Update and Report on Managed Care Enrollment**

  By Tom Sargent, Management Analyst IV

Mr. Sargent explained that the chart he presented spans from January 2012 through March 2016. He stated that what has happened to Medicaid enrollment is remarkable due to the Affordable Care Act (ACA). He went on to add that in January 2012 the managed care penetration was about 56% of Medicaid enrollment and grew to 69% by March 2016. In October 2013 the division began to move people from CHIP to Medicaid, and in January 2014 began enrolling the expansion categories (Fee-for-Service (FFS) and Managed Care Organizations (MCO)). Together they represent approximately 210,000 new members since the ACA launch. He commented on the fact that the Legacy Medicaid FFS and Legacy Medicaid MCO has also grown due to the increased awareness of the need for insurance and finding out that they actually qualify for Medicaid. Mr. Sargent spoke of the volatility represented by churn between the benefit programs and forced redetermination by Welfare.

- **Presentation on Medicaid Managed Care Expansion (see attached presentation)**

  By Tammy Ritter, Chief of Managed Care & Quality

  Ms. Ritter spoke about a Request for Proposal (RFP) for a vendor to help evaluate whether services need to be put into or brought out of managed care, if we need to expand the service delivery area or the population served (Long Term Services Support or Aging and Disabled). This contract is still in negotiation.

  Ms. Ritter also stated that they have been having listening sessions and have met with different focus groups such as the Hospital Association.

  Chairperson Rosaschi asked if these listening sessions are stemming part of the "rumor" that the question at the beginning of the meeting was about.

  Ms. Ritter replied that she is sure it is.

  Dr. Murphy asked if they were looking for vendors outside of Amerigroup and Health Plan of Nevada (HPN).

  Ms. Ritter answered yes, they are looking for someone with experience with other states transitioning to managed care.

- **Report on Access to Care Plan**

  By Tammy Ritter, Chief of Managed Care & Quality

  Ms. Ritter began her report by saying that CMS made a new rule, effective April 8, 2016, that states must have data driven processes to document whether Medicaid FFS payments are sufficient to enlist providers and ensure beneficiary access to covered care and services. She said we need to develop a plan that has to be data driven, include methodologies, assumptions and trend analysis for impact to access to care that includes rights and geographic areas. The focus areas that

need an analysis are primary care services, physician specialist services, behavioral health, pre and postnatal obstetric services and home health services. The regulation requires the plan make public the minimum beneficiary needs by cold calls, hot lines, ombudsman or surveys. We have to track the information received, post it on the web, be transparent and do the data collection. The plan must include sources, methodologies and base lines. It has to be reviewed and updated every three years. The plan also has to address corrective actions. Ms. Ritter said that some of the implementation can be redesigned service delivery strategies, increasing provider enrollment and retentions activities, modifying payment rates or improving care coordination.

Ms. Ritter said that one of the requirements of the plan is that it be done in consultation with the Medical Care Advisory Committee (MCAC) so the division will be bringing a plan to the July 19, 2016 meeting. She also stated that every time a SPA is submitted that may negatively impact or restructure rates, we will have to have an analysis done within 12 months. This is strictly FFS as of now, but they are expecting a similar plan for MCO in the near future.

No questions or comments.

- **Report and Discussion on the MMIS Modernization (see attached presentation)**

  By Sandie Ruybalid, Chief of Information Services

  No questions.

  Chairperson Rosaschi thanked Ms. Ruybalid for the update.

- **Report and Discussion of Provider Revalidation**

  By Tammy Moffitt, Chief of Program Integrity

  Ms. Moffitt informed the committee that this project was started in June 2012 and finished it in June 2015. Part of the problem was the division decided not to terminate the providers who didn't revalidate. The goal was to focus on providers who had not revalidated up until March 25, 2016. She said that CMS was not happy with Medicaid for not terminating providers who had not revalidated. In January 2016, CMS came out with new revalidation guidance and they wanted to better align revalidation activities with both Medicare and Medicaid. Ms. Moffitt went on to state that the DHCFP was given two set of rules. First, the DHCFP needed to notify all providers by March 24, 2016 of the revalidation deadline. Second, the process needs to be done by September 25, 2016. The first guideline was met by March 16, 2016. The deadline to revalidate is August 31, 2016. At that time, any provider that has not revalidated will be terminated. Ms. Moffitt said that her unit has done a lot of outreach to the providers, including, but not limited to emails, phone calls, web announcements and newsletter articles. They have also gone to the MCO quarterly meeting and asked the MCOs to help out

with the revalidation process. The next step is clearing up the last few providers they haven't been able to contact. These providers have very little claim volume and probably aren't interested in being Medicaid providers any more. Then they will be moving to a five year revalidation process and they will be terminating as they go.

Chairperson Rosaschi asked what is included in a revalidation.

Ms. Moffitt explained that it is just updating all their information.

Chairperson Rosaschi wanted to know if it was a long application process.

Ms. Moffitt replied that it was like reapplying. The problem is that Nevada never asked them to update their information. One of the problems is loss of contact. The division gets a lot of returned mail.

Chairperson Rosaschi is concerned that we might be losing mental health or dental providers because there are so few of them.

Ms. Moffitt responded that it could happen. That's why her unit looks at claims volume and access issues and focuses on getting them revalidated. Mainly it is physicians that haven't responded. But there is a large number of mental health providers as well.

Dr. Ravin wanted to know if a provider worked in two different facilities would they have to complete the process twice. Is there a way of tracking to make sure they are not having to duplicate the work?

Ms. Moffitt explained that this is part of the problem. She is hopeful that as the web portal becomes more advanced they will be able to resolve those issues. Once the information is in the web portal, the information should be stored there and will automatically generate the information whenever the provider reapplies or updates.

- **Discussion on Changes to Ambulatory Surgical Center (ASC) Reimbursement**

  By Tiffany Lewis, Manager of the Reimbursement, Analysis and Payment Unit

  Ms. Lewis reported that currently Nevada Medicaid reimburses ambulatory surgical centers using a methodology based on assigning a "flag" for every code they reimburse that fall into nine buckets. This methodology was based on an old Medicare process. Medicare has since updated their methodology, but the division has not. The DHCFP is proposing at looking at Ambulatory Payment Classification (APC) methodology. One of the issues is that we only have nine buckets while Medicare has about 900. The DHCFP's current ASC range is from $400 to $2,000. If we went with the APC the range would be from $15 to $23,000. This provides a more appropriate reimbursement structure for services

provided and aligns with CMS methodologies. Ms. Lewis went on to state that some current services will receive a reduction, however, it also provides the opportunity to drastically increase rates for complex services.

Chairperson Rosaschi asked if the vendors felt like they were gaining or losing with the changes being made.

Ms. Lewis replied that it will depend on the individual facility. She said that they ran their data in aggregate of what everyone is doing. It should balance out for a lot of the providers to be more appropriate for the higher cost, higher complex services.

Chairperson Rosaschi asked how is it going to impact the whole system when we make the changes?

Ms. Lewis stated that they plan on having some public workshops to show the providers what the new structure would look like before going to public hearing. She said that a few providers have reached out to the division asking why the DHCFP is not following this methodology.

VIII Discussion of and possible election of Vice-Chair

By Chairperson Rosaschi Rosachi, MCAC Chairperson

Chairperson Rosaschi commented that every once in a while the Chairperson cannot make a meeting and we would need a Vice-Chairperson. Nominations are open even though not all committee members are in attendance.

Ms. Epidendio nominated Dr. David Fluitt.

Dr. Murphy seconded the nomination.

Chairperson Rosaschi noted that Dr. Fluitt is not in attendance but we can vote him in.

All voted aye.

Chairperson Rosaschi requested that staff notify Dr. Fluitt that he has been selected Vice-Chair.

IX Public Comment on Any Topic

No comments

X Adjournment

Chairperson Rosaschi adjourned the meeting at 10:54AM